Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING
August 19, 2010
Elihu M. Harris State Building
Oakland, California

In Attendance
Chair Angie Wei

Commissioners Catherine Aguilar, Faith Culbreath, Sean McNally, Kristen Schwenkmeyer, Robert Steinberg, Darrel (Shorty) Thacker

Executive Officer Christine Baker

Call to Order

Approval of Minutes from the June 24, 2010 CHSWC Meeting

CHSWC Vote
It was moved, seconded and passed unanimously to approve the Minutes of the June 24, 2010 meeting.

Lien Study Interim Briefing
Lachlan Taylor, CHSWC

Judge Taylor stated that feedback from the preliminary briefings in June revealed misunderstandings that were left by the first briefing. The data sources or profiled nature of liens included: paper lien filings which were sampled from five high-volume offices; eFiled liens through the Electronic Adjudication Management System (EAMS); a survey of claims administrators from across the state; and lien census data from the Division of Workers' Compensation (DWC). He stated that feedback indicated that it was not clear that the profiles of lien characteristics were based only on data from the statewide survey; the other sources had not yet been incorporated in the first briefing. Feedback also revealed that amended liens had not been factored out, and that the total amount in dispute struck many as excessive.

Judge Taylor stated that since that time, the first focus was to look at amended liens, from a sub-sample coming from the five offices in which he could look at the entire amount of each lien to see if they were new bills or bills that had been previously filed. Judge Taylor stated that from that he could conclude that less than 10% of the face value of lien dollars had been previously filed. He stated that that process led to other reasons to pare down the data. About 3% of liens were duplicates; either the same lien was filed for more than one workers' compensation claim, or the paper claims came into the system by two different routes and were entered into the

system twice. He stated that 4% of the dollars turned out to be duplicate filings. Most interestingly, outliers were found that were either extraordinary liens or faulty data entry; either way, the outliers would distort the findings. Only 16 medical liens exceeded $90,000, and 5 of them appear to be outliers and are being discarded.

Judge Taylor stated that as a result of this, the data are cleaner, but that the findings do not change that much. The initial report briefing gave a profile of types of liens, by count and by dollars in dispute. After the adjustments, the profile does not change very much. The initial briefing examined which providers were filing medical liens; physicians were the largest percentage of lien filings and by far the largest percentage of dollars in dispute. After removing the amended liens, duplicates and outliers, physicians dropped to second place in terms of dollars in dispute, behind hospitals, but the total number barely changes.

Judge Taylor stated that while a final report was planned for this meeting, this is as far as Commission staff had progressed due to conflicting demands since June. At this point, similar distributions are observed, almost identical types of liens; there are slight changes in the distribution of provider types but not by much. Dollar amounts will be reduced, so that there should be less disbelief about the total amount in dispute. The total amount figure had not yet been calculated, but the overall policy significance of the information was unlikely to change. He stated that he was pleased that they could trim the data because the importance here should not be debating the precision of the measurement, but the policy implications. With more confidence in the data, the open public policy debate about what to do next should be able to progress.

Judge Taylor stated that had not yet been able to pin down the overall lien volume for the year. The estimate last time was around 300,000 liens for this year. He stated that they have more than half a year's worth of data and should be able to refine that estimate, as well as see how the sources of data compare. It will be possible to drill down further into the issues using the survey data and look not only at the headcount but also at the dollars in dispute and the various issues that arise. A final report should be available for the next meeting. He stated that in order to avoid further delay, he would like to ask the Commission to release the draft report for public comment in advance of the meeting so that, if warranted, the Commission may choose to vote to approve the final report at the next meeting.

Chair Wei stated that there is no scheduled meeting until December, so Commission staff is asking Commissioners to entertain and pass a motion that would allow for this study to go out for public comment when it is completed and then to consider it a final study in December. Judge Taylor stated that this process would also allow for public comment to be more thoroughly considered.

Questions from Commissioners

Chair Wei asked whether it was more important to focus on size of liens or number of liens and whether it was more a problem of too many small liens. Judge Taylor responded that the number of liens, regardless of size, affects the workflow at the Workers' Compensation Appeals Board (WCAB) and chokes the decision-making process. The size of the liens affects how much is at risk, as well as what is the amount of uncertainty that insurers are reserving for and can charge

for, and it affects how many barriers there are for medical providers who may or may not be available to workers if they think they cannot get paid. The fact that the total scale comes down might mean that there are less potential savings as a solution. He stated that both measurements provide useful information, but he does not know which might be more important.

Chair Wei stated that it jumped out on the revised figures that Copy Services were 20% of the total. She stated that her assumption is that those are small liens. Judge Taylor responded that that was correct; they do jump out more in the revised figures as he did a better job of separating them out from the other categories. He stated that if there were a desire to get those types of liens out of the system, then that could be a subject of future discussion.

Public Comments or Questions

Steve Cattolica, California Society for Industrial Medicine and Surgery and the California Society for Physical Medicine and Rehabilitation, thanked the Commission for its efforts and asked if there will be an effort to include the lien filers and the lien representatives in the polling that was done from the sources. Judge Taylor responded that he had spoken with lien filers about issues in designing solutions, but as far as statistical studies or surveys to profile overall behavior, he could not come up with a feasible way to get a representative sample of data. He stated that there will not be a data analysis of lien filers. Mr. Cattolica asked whether the folks Judge Taylor spoke with were satisfied with the absence of that information. Judge Taylor stated that they would like to have such analysis, but he has not found a way to do that feasibly. Mr. Cattolica asked if those surveyed had any ideas, and Judge Taylor responded that they did not. Judge Taylor then asked whether Mr. Cattolica had a suggestion to do this feasibly, and Mr. Cattolica stated that he did not.

Mr. Cattolica stated that in the last briefing, a fair proportion of liens filed were filed on the same date of service, and he asked whether Judge Taylor discovered how that could possibly happen. Judge Taylor responded that he had not made progress on that issue; he stated that the best he might be able to do is to look more closely at specific examples of some of the cases where that happened. Anecdotally, it appears that the billing agent/collection factor is part of the transaction; it is set up to operate that way, rather than the medical provider bills for their own services and when they cannot, they sell their receivables to someone else. Mr. Cattolica asked whether given that knowing what the codes say with respect to when a lien can be filed, whether those liens should be removed from the sample. Judge Taylor responded that regardless of who filed the lien, it was still filed. It should be separately identified but not thrown out. It is still a lien in the system for the judicial process to go through, and he did not know if by the time it reaches a hearing whether it is thrown out or the date is disregarded. Mr. Cattolica stated that he believes that is still an issue, and the analysis needs to be more accurate. Judge Taylor thanked him for his input.

Chair Wei stated that the public can submit questions to the Commission, and staff will be happy to receive the questions and comments.

CHSWC Vote

Commissioner Aguilar moved to adopt this study pending its conclusion, and Commissioner Culbreath seconded. The motion passed unanimously.

QME Study Draft Report
Lachlan Taylor, CHSWC

Judge Taylor stated that this subject has also had a preliminary briefing once before. In review, the Qualified Medical Evaluator (QME) process is at the heart of much of the dispute resolution process in workers' compensation and much of the determination of benefits that injured workers are entitled to receive. That process has been substantially overhauled over the past decade, and there are questions about how well it is achieving its goal. There have been complaints that there are too few QMEs, so that there are delays in dispute resolution. There have also been comments that QMEs are dropping out because they cannot get enough business to make it worth their time. There have also been comments that it is getting difficult to schedule Agreed Medical Evaluators (AMEs), with a long wait times, worse than before. He stated that they tried to understand how all this could be true.

Judge Taylor stated that the number of physicians registered as QMEs has indeed been dropping since 2005, but the number of injuries occurring two years earlier (equating to around the time one needs a QME) has been dropping at about the same rate. This looks like a fairly good match-up. However, the number of requests for medical panels went up dramatically, peaking in 2008, and even after coming down, the number has grown much more than the number of injuries. It then does appear to be an increase in demand for reports per doctor, even though the number of requests is not much different than in 2005.

Judge Taylor stated that in the last presentation on the subject, Frank Neuhauser explained why there was a peak and then a fall-off; it seems to be coincident with the *Sandhagen* decision which told claims administrators that the QME was not available to them as a means of evaluating medical necessity. Claims administrators had to use utilization review (UR), and QMEs are available for an objection by an injured worker to a UR decision. Judge Taylor stated that that was the only plausible explanation they could account for a fall-off right after the *Sandhagen* decision.

Judge Taylor stated that they reviewed the proportion of ratings being done by primary treating physicians (PTPs), QMEs for represented and unrepresented cases, and AMEs. The number of QMEs for represented cases has grown a great deal, while the number of QMEs for unrepresented cases is more or less what they were before, about 25%, and PTPs seem to be moving out of doing permanent disability (PD) evaluations. Some of the problems of getting QMEs and the delays may not be due to the total number of doctors, but due to not having the number of doctors in specialties where they are needed. He stated that it is particularly the case in orthopedic, pain and psychiatric specialties, where the number of those cases has risen much more than the percentage number of those doctors over the past five years.

Judge Taylor stated new findings that look at the assignment of QMEs. A panel of three QMEs is assigned based on the specialty requested and based on the worker's address; a circle is drawn around that address until there are at least enough doctors in the pool to draw seven doctors, and then three are drawn. If there are not at least seven doctors, the circle is expanded until there can be seven. However, a physician can have multiple locations and can show up in different circles that get drawn, or may have multiple locations in one radius of a worker, thereby increasing the chances of being drawn for an assignment. As a consequence of the ability of a physician to appear multiple times in the pool, there is now 63%, almost 64%, of physicians who have just one location and who receive 23% of the panel assignments. This does not mean they are doing the examinations, just that they are among the three selected to do the exam. On the other end of the range, there are just under 4% of physicians who have 11 or more locations appearing on almost 40% of the panels. Over the years, there has been a huge shift towards a few high-volume physicians dominating QME assignments. This concentration may be leading to delays in scheduling, as well as declines in the number of physicians willing to participate, since if they do not have multiple locations, they will not get as much business.

Judge Taylor stated that if there is a small cadre of high-quality physicians that everyone would accept as being always correct, this concentration may not be a bad thing. What they find instead is that high-volume QMEs evaluate cases differently from the rest of the QMEs in the group. Looking at the 30 high-volume doctors who showed up most in QME pools, they typically rated between 7%-21% lower than reports by other evaluators. He clarified that he does not mean 21 PD rating points, but 21% of the average rating value. This tendency extends to whatever reports they are doing, whether they are a PTP, selected as AME, or QME in represented or unrepresented cases; their behaviors are the same. It is also consistent whether it is the rating they did under the 1997 schedule or under the 2005 schedule. Judge Taylor presented a chart demonstrating the direction of the difference between the high-volume doctors. If the difference is statistically significant, then the cell will be filled in; if rated lower than average, it is shaded red, or if rated higher than average, it is shaded green. There is not much shaded green on the chart. The chart breaks out the type of role and indicates whether it is the new or old schedule.

Judge Taylor stated that the conclusions are that some of the perceptions about the QME process may still be based on when there was a spike in requests that the system could not keep up with. The spike was probably driven by medical issues, because it went away when some of the medical issues were resolved. The current problems with delays are likely the result of the mismatch between the number of medical specialties, especially orthopedics, and the number of cases that require those specialties. There is also concern about the concentration of assignments among a few high-volume QMEs who are rating lower. He stated that if the goal of the new QME system were that the outcome of the case should not depend on which doctor's name is on it, the system has not yet gotten there.

Questions from Commissioners

Chair Wei asked how many QMEs are in the system. Judge Taylor responded that it was around 5,000; it was 7,000 before, but he would have to refer back to the report for the exact figure. Chair Wei then asked how many QMEs the system should have. Judge Taylor responded that he did not know and asked for comments on the correct standard to answer the question.

Commissioner Steinberg asked how the sample of doctors was chosen to compare with the high-volume doctors. Judge Taylor responded that there was no sampling in this case; that it was a straight-forward comparison from the entire database. To compare the high-volume physicians with all the others, they took the 30 top and compared them with the others. They averaged, for example, all of the hand specialists' reports; they should either all look the same or else they are drawing their patients from different pools, or one of them just sees things differently. He stated that if the doctors' averages do not look at all the same, and yet they all examined patients drawn randomly from the same pool of exams, it must be because the doctors do not all see things the same way. One could say that rating by an AME is bound to be higher, because AMEs are selected for more complicated cases. However, the analysis compared AME to AME, and the same comparison was made between unrepresented QME with unrepresented QME. He stated that he cannot see any reason that they were not being drawn from very similar populations of patients. The only explanation for this tendency to a conservative rating is that these high-volume doctors tend to see the cases differently. Commissioner Steinberg asked why they would see things differently. Judge Taylor responded that he did not know and that he has only presented the facts, but that he looked forward to the community's interpretations.

Public Comments and Questions

Johnella Shackelford, an injured worker, stated that in response to the question about why high-volume doctors rate lower, the last time she was at a Commissioner meeting, she understood that a QME doctor was supposed to spend a certain amount of time with the patient/injured worker, 30 minutes or so. She stated that she discussed this fact with others, and she stated that they are finding that often, a QME doctor is not spending that amount of time with the patient. She stated that it is possible that the high-volume QMEs start off with a certain perception, rather than starting from zero with each injured worker. She stated that that could explain some of the difference.

Ms. Shackelford stated that her question is whether there is a way for the unrepresented injured worker to find out who the high-volume or multiple-location QMEs are. She stated that they are just picking a panel of three doctors that they know nothing about, and that as she mentioned at the last meeting, more and more people are then getting a notice once they schedule with a doctor that the appointment is not going to be there, but that it is actually going to be 30 or 40 miles further away. She reiterated her question about whether there was a way to know more about the doctor before chosen for a panel, especially if they do not have a location that they have listed. Judge Taylor responded that he did not how one would know that from a panel list, at this point, and that that would be something to consider.

Chair Wei stated that it begs the question of how a QME could spend half an hour with a patient if he or she is running around to 11 locations. She stated that she believes this is an area of study that the Commission is committed to developing policy recommendation to address.

Steve Zeltzer, California Coalition for Workers' Memorial Day, asked whether they studied the time length from date of injury of the worker to the adjudication of the dispute or action by the QME. Judge Taylor responded than in the earlier briefing they did, and that it would be in the report as well; it was not discussed today. Mr. Zeltzer asked what the average time was. Mr.

Taylor responded that he did not remember, but after looking through the report, he stated that they did notice that the time between the writing of the report and the rating was going down.

Mr. Zeltzer stated that if a worker is injured and is not treated properly and in a timely fashion, there is deterioration of a condition in many injuries. He stated that they have experience with many injured workers who have to fight a QME and others for their treatments, and it has taken months, even years. Judge Taylor responded that many of the timelines they studied were on permanent disability (PD) cases because they could follow them from beginning to end. In medical treatment cases, they do not see what happens in the administrative database that they use. Mr. Zeltzer suggested that any study that looked at the treatment of injured workers with QMEs would have to include the time of the injury and the length of time to get treatment. He stated that if QMEs were set up to help injured workers, they are actually preventing them from getting their injuries treated because of bureaucratic obstacles; this defeats the purpose and means that workers are suffering instead of getting their injury treated.

Commissioner McNally asked whether when Mr. Zeltzer said that a QME was an obstacle to getting treatment, he meant the process or the specific QME. Mr. Zeltzer stated that he meant the QME process; he stated that the QME process was pushed by the insurance industry, and it is being gamed by having pro-company doctors making decisions about whether workers are injured or not and whether they should get treatment. Judge Taylor stated that the QME process was designed to be swift and has some very tight timelines, and it is failing the community if it is taking months and years to get something resolved. Mr. Zeltzer stated that they have experiences with many workers who have been injured, and it has taken a year to get their injuries treated. He stated that furthermore, workers who have been denied treatment by QMEs for their injuries end up going onto to social security insurance (SSI) and having the federal government, which is the taxpayer, take care of their injuries. He asked if there was any effort to include that in the study. He stated that there is an important aspect of cost-shifting that is happening with workers' compensation.

Judge Taylor stated that the dispute resolution process is supposed to help sort out which injuries are compensable and which are not. Sometimes, one party or the other will believe that the process gave the wrong answer. However, a working dispute resolution process will sort out some cases and say which are compensable and which are not and belong in another system. Mr. Zeltzer asked whether there was any evidence or studies of what workers experience. He stated that when someone is injured at work and denied by a QME, they then drop out of the system and go on SSI, and their injury is taken care of. He stated that he would call that a case of cost shifting by the insurance industry and the QME process. Mr. Taylor stated that that would be outside of the scope of the study discussed.

Mr. Zeltzer stated that his organization was beginning to question the role of ACOEM, which is a "trade, corporate, employers' association of doctors, drug industry and healthcare industry," which is making determinations about workers, whether they are injured and whether they should get treatment under ACOEM regulations. He stated that he would like to know more about those doctors giving pro-company reports, denying workers their rights, and whether they are ACOEM doctors; that would be an interesting study. He asked who the doctors are representing, because they are not representing injured workers.

Dr. Jack Thrasher stated that he came down from Sacramento at Mr. Zeltzer's request and stated that he seconded Mr. Zeltzer's comments. He asked what program exists that shows that the QMEs are qualified. He stated that he has seen many reports over the years where people have had definite neurological injuries and the QME gave them a standard physical examination rather than a detailed neurological exam. He stated that he has seen patients who have closed their eyes, stand erect, and fall down. He asked who sets the standards for QMEs and asked for a study on that. He stated that he would participate in such a study.

Suzanne Marria, an attorney with DWC, stated that she has some familiarity with the QME process. She stated that she wished to answer an earlier question about how an injured worker who receives a panel list can know a high-volume QME. She stated that anyone can go to the DWC website and look for the QME database, which is a way to search for doctors. She stated that there are multiple ways to search for doctors, including by name. She stated that when one enters a QME name, the system will show all the locations.

Thomas Pegnim, with the Workers' Compensation Section of the State Bar of California, stated that his comments were based on personal observations and not based on anything related to the State Bar. He stated that the QME panels in orthopedics that he sees as a practitioner in Contra Costa County are completely dominated by the high-volume doctors. He stated that he has come to some observations about how they have what they have on the panels. He stated that he believes that market forces drive these doctors to the panels. The better doctors who take more time are more considerate of the needs of the parties and the accuracy, and they tend to rise to the top and become AMEs. He stated that they take the time and they are paid for taking the time, and they are well-paid for taking the time. He stated that with these, doctors, bills are paid on time, depositions are taken in a timely manner, and the industry respects them. He stated that those people who do not have that type of standing tend to drift to high-volume practices, and that is how they make their money. He stated that when he sees unrepresented people come in with panel QMEs from high-volume practices, they are always terribly low; they do not consider *Almaraz Guzman*; they do not consider all the factors. He stated that he believes that the cause is that industry makes most of the choices on the panels. He stated that when he asks an unrepresented worker how they chose their panel, they typically respond that their claims administrator told them who this person was and then they chose that person, or that the physicians are all the same, so they let the claims administrator choose. It is very rare for a client to ask who they should choose. He stated that as a result, the high-volume doctors pander to the insurance industry because the insurance industry is doing the choosing. He stated that those doctors are in it for the volume and the money, and while he is not saying that money is bad, he is saying that their interests are different from perhaps the AMEs' interests.

Mr. Pegnim stated that he finds it very disturbing that high-volume doctors have absolutely no connections with the community. Many of them are out of Southern California; they come up to Northern California, and they will never have to sit in the hospital cafeteria and look at a local spine surgeon or local neurologist and say, "Oh, by the way, I told your patient who is suffering that he cannot have his epidural, by the way, I told that person he could not have his surgery and I'm screwing up your client." He stated that they have no local context and no accountability which local doctors do have to the community, the medical community and the legal community. He stated that they act as an impervious group that goes from place to place and generally

panders to the insurance industry. It is a market force factor, but he does not believe the system works when there are people from outside of the community who do not care. He concluded by stating that this is a personal observation.

Judge Taylor stated that Mr. Pegnim's observation that high-volume doctors not being picked very much for AMEs would seem to be corroborated by the fact that there were only four high-volume doctors who had enough AME reports to be statistically significant, and most of them did not have any AME reports under the 2005 schedule.

Commissioner McNally stated that he practiced as an attorney in the area and was a certified specialist for many years, and he runs a self-insured program; he would agree with the dysfunctional state of the QME system and with the high-volume doctor issue. He stated that he is in Bakersfield where they do not have QMEs; as a consequence, they do not get panels; they send people to Santa Barbara and Los Angeles and Thousand Oaks, anywhere but where they are, so the doctors are not in their community, they are not representative of the community, and they do not understand what all of the people who are injured in the community do (for work); they are a rural community and an agricultural-based and oil-based community, and those doctors do not understand the workers or the community. He stated, however, that it has not been his experience that it is strictly pandering to the insurance industry. He stated he sees Information and Assistance (I&A) officers influencing the process a lot, inappropriately so; he also stated that he sees local chiropractors and local physicians who are marginal treaters. He said that they could have the same criticism of local treaters who influence this QME process because the only person they know who to go to is the one that they get directed to, the I&A officer, or they get directed to some chiropractor. These chiropractors, and it is not strictly chiropractors but also marginal MD treating physicians, are in the same network, the same loose organization of doctors who refer within themselves. He stated that he takes issue with the idea that the system is rigged by the insurance industry; he is not taking issue with the idea that the system is broken.

Chair Wei asked whether the system is partially rigged and stated that it will be rich discussion for the written report.

Mr. Cattolica stated that they found that only four of the high-volume physicians were recognized as AMEs on a regular basis. Judge Taylor clarified that the four related to ratings under the new schedule. He stated that either the rest are doing ratings that are indistinguishable from the general population, which would be a good thing, or they are simply not doing enough that can be quantified. Mr. Cattolica asked if they were chosen by both sides. Judge Taylor further clarified that these doctors were found by going through all the Disability Evaluation Unit (DEU) ratings, parsing out the names of doctors from the rating. Mr. Cattolica asked whether all the QME reports by high-volume QMEs were rated by DEU, or whether there are other reports written that are not rated. Judge Taylor responded that only if it is an unrepresented case and there is a panel QME. Mr. Cattolica stated that only if there is PD, does the report automatically go to the DEU; if it is a represented case, the choice to be rated by the DEU and is up to the attorneys. Judge Taylor stated that in a represented case, there will be some selection in what DEU will see. If it is not a PD case, in this analysis, it is screened out. Mr. Catollica asked how they reconcile what they found with the claim from the third-party reviewer agencies that around

80% of all the QME reports in California are incorrect in hindsight. Judge Taylor stated that he is not attempting to reconcile that and would not comment.

Commissioner Steinberg stated that it was his understanding that represented cases go to AMEs most of the time. Judge Taylor responded that he was not sure of that fact. He stated that he sees a lot of represented QMEs; parties cannot agree on an AME, and one or the other wants to take their chances on the pool. Commissioner McNally stated that it is that or that it is so difficult to get in and get an AME, one that both parties agree on, that it is a year and a half out and they cannot wait.

Brenda Ramirez from California Workers' Compensation Institute (CWCI) stated that the rating levels vary by the body part quite often; some body parts may be more frequently rated or go to QMEs with a particular specialty. She asked whether the average rating level might be affected by those typical rating levels by different body parts. Maybe that is why they are seeing the results that they are. Judge Taylor responded that specialty was matched against specialty, so if it is a hand specialist, it is matched against a hand specialist, or if it is a hand-ortho-spine and shows up three times, they would be matched. Ms. Ramirez asked if they looked at the accuracy of the QME evaluations and how they were written up, per the AMA *Guides.* Judge Taylor stated that the goal was not to say who is right, but to look at the differences in behavior.

Ms. Ramirez stated that if they want to look at the effectiveness of the QME process, it is important to look at the timeframes. There were delays in getting a panel, but DWC is caught up on those delays, given her understanding. She stated that there are delays in getting appointments, especially with AMEs, where sometimes people do wait for six months, nine months, a year or more. There is also the time to get the report. She stated that the reports are very late most of the time, and that does delay treatment for injured workers. She also stated that there are delays in getting the rating. Judge Taylor stated that they did look at delays in a previous presentation, and that it will be part of the final report as well. Ms. Ramirez stated that, similar to Commissioner McNally, she questioned the idea that the QMEs with multiple locations are primarily insurance company doctors. She stated that that is not what CWCI has seen; she stated that claims administrators are often concerned with the quality of the evaluations of many of the multi-location QMEs.

Chair Wei stated that it seems like one of the fundamental issues is increasing the quantity and quality of QMEs and AMEs, so that they can address the delays and the problems getting appointments. She stated that she would like to request some thought on the subject. Judge Taylor responded that one of the considerations that policymakers might make is whether to pay more for specialties that are in short supply and whether that would attract more experts. Chair Wei stated that there might also be some type of incentive to go to more rural areas or some kind of mapping where there is a paucity of QMEs or AMEs in a region and create some kind of regional incentive pay or some adjusted incentives, rather than forcing workers to travel farther to get to them. Commissioner McNally stated that he agreed, but that they needed to also tighten up the regulations to disallow physicians with multiple or a dozen locations in places that they have never been, though they may have a P.O. Box; these physicians do not know the community.

Chair Wei asked if Commission staff could look at which issues DWC might be able to pursue without any change in the statute, whether through policy or regulation, such as not allowing a P.O. Box to be listed as the address, so as to address this quickly while they address the longer-term solutions. Judge Taylor stated that they might prepare different policy options.

Commissioner Culbreath stated that in reference to the DWC attorney's comment that people could go on the DWC website and look up a doctor and their locations, they should consider that everyone does not use the Internet, and there may be a way to have that information be more accessible to those who need it. Ms. Marria responded that workers could call the Medical Unit, or they could go into an I&A office and have an officer look it up for them. She stated that switching locations is a violation of the regulations; unless someone calls and reports that the location of the appointment is different than the address on the QME panel letter, DWC will never know about it. She stated that the Legal Unit of DWC or the Medical Unit would be the appropriate group to call. The QME who is selected is supposed to file a form when the appointment is scheduled with the Medical Unit (Form 110), and an improper change of location is grounds for discipline. This issue has been addressed from a disciplinary standpoint before, and there may be open cases on this subject. In the last QME rulemaking, there was a proposal to try to address the problem of multiple locations, but that proposal did not survive the rulemaking, apparently based on public comment. If this is an issue that the Commission is recommending that DWC should look at again, it is something DWC has been aware of.

Commissioner Aguilar stated that she would like to ask DWC to give the Commission information on the disciplinary actions, because even if a complaint is filed, they do not know what actually happens. She stated that claims handlers she knows are concerned about complaints because there are so few doctors that they will start losing them; that is why they pay their bills even though they get the report in late; she stated that the situation was that if they do not pay their bill, they will not see their patient next time. She stated that they are getting what she considers threats from doctors who say if you do not pay ahead of time or do this or that, then maybe they will not have time to see their patient or get their report done in a timely manner. Ms. Marria stated that if they get a threat from a doctor as described, they should report that to DWC as it is a violation, and action will be taken immediately. Ms. Marria stated that the DWC website lists the names of physicians who have had disciplinary action. Chair Wei asked if the doctors end up on the DWC disciplinary list whether they also get dinged at the Medical Board. Ms. Marria responded that she believed that the practice is to mail a copy of the disciplinary final order to the Licensing Board. Chair Wei stated that she would like the Commission to look into that too.

CHSWC Vote

Commissioner Aguilar moved to circulate for public comment/feedback the draft QME Study Final Report and then post as final after 30 days, and Commissioner Thacker seconded. The motion passed unanimously.

Workers' Compensation Medical Study Update
Barbara Wynn, RAND

Barbara Wynn noted that she spoke to the Commission several years ago with the preliminary findings of the study focusing on medical provider networks (MPNs). The previous findings are currently valid. That presentation focused on best practices and Division of Workers' Compensation (DWC) activities to strengthen access to medical quality issues under MPNs. She stated that this presentation focuses on MPN organizations and issues related to potential policy changes. The current findings are drawn from earlier stakeholder interviews that have been updated both in terms of discussion and environmental scan of literature and reports that the California Workers' Compensation Institute (CWCI) has done and an analysis of the Workers' Compensation Information System (WCIS) 2007 data. Ms. Wynn stated that she is grateful to DWC for the assistance it has given. She stated that she believes the audience is familiar with basic MPN provisions that were effective on January 1, 2005, and did not think it was necessary to summarize them in the presentation. .

Ms. Wynn stated that for most of the MPNs, the applicants have been insurers. Out of the 1327 active MPNs as of April 2010, insurers had applied for 829 MPNs and self-insured employers had applied for 451. In addition, Joint Powers Authorities (JPAs) and the State of California; were applicants for 45 and 2 MPNs, respectively. One of the most bewildering factors is that many applicants have applied to multiple MPNs. If you look at the distribution, 532 applicants have applied for only one MPN, and most of those are self- insured employers. In addition, 136 applicants have applied for two to nine MPNs, and there are two applicants that have 36-40 MPNs. Ms. Wynn stated that it is difficult to separate the different third-party administrators and differences in geographic service areas across the MPNs. Also, physicians are involved in multiple networks. This would be difficult for an injured worker to figure out.

Ms. Wynn stated that one of the challenges has been to determine the MPN penetration rate and the percentage of care provided under an MPN. It is important to know this since care is provided under different contracts and is not the necessarily the same as care provided by MPNs. Different policies' processes apply both in controlling where the injured worker may obtain care and in access standards, and different appeals processes and different pre-designation rules apply. However, the distinction between MPN and other contract care may not be clear-cut. For instance, 47% of the MPNs use the health care organization (HCO) networks as their starting point. HCO networks are no longer operational because of MPNs. A payor may roll over from an HCO controlling 180 days of care to an MPN, and all of that care may be coded as contract care. CWCI reports define all network care as MPN care; according to CWCI, 61% of payments for first year for Accident Year 2008 services were furnished by a network provider. That may be an overstatement (all payors in the CWCI sample had PPOs prior to MPN reforms). Ms. Wynn stated that WCIS data were collected separately on MPN and other contract care. MPN payments are about half as much as other contract care but the total contract care (MPN and other) is close to CWCI numbers. The lack of an MPN identifier or the employers using a particular MPN makes it difficult to assess the reporting accuracy in the WCIS data. Ms. Wynn stated that the MPN penetration rate and other contract care rates vary across specialties: psychiatry and anesthesiology are mostly non-contract care, whereas occupational medicine, as well as other care such as physical rehabilitation, is mostly contract care whether it is within an MPN or

another contract. Ms. Wynn noted that the rate of contract care is higher for recent injuries. For the year 2007, 41% is non-contract care as opposed to older injuries where about 70% is non-contract care.

Ms. Wynn stated that the University of Washington recently completed a survey on the access to quality of care in workers' compensation, and this study is important to understanding the perceptions of care and barriers to care. Three surveys were done: one was done prior to the reforms; one was done by UCLA in 2006; and the most recent one was done by the University of Washington in 2008. The satisfaction expressed by workers with their main provider remains about the same pre- and post-reform, and it is also the same for the overall satisfaction of care. Overall satisfaction (as compared to the satisfaction with the main provider) is lower. The survey also finds only 45% of the providers agree that injured workers have adequate access to care. Utilization review and the ACOEM guidelines are most often cited as barriers to care. One-third of the surveyed physicians indicated an intent to decrease or stop treating workers' compensation patients. The University of Washington researchers found that the probability that a provider would intend to decrease or stop treating workers' compensation patients was greatest if they were unfamiliar with workers' compensation laws and guidelines, if there was legal involvement, or if there was administrative burden/paperwork or inadequate/discounted fee schedule, or dealings with difficult claims adjusters/insurers. Ms. Wynn stated that these data are for physicians in an MPN who had 15 or more years experience with workers' compensation. The probabilities were statistically significant after controlling for the practice setting MPN involvement and experience.

Ms. Wynn stated that the bill adjustments reflected in WCIS data reinforce those perceptions. The RAND research team separated the bills into two types: one where there was no payment for a line item; and the second where the line item got some type of payment. There was duplicate billing as well as billing errors that were created by non-updated fee schedules. Adjustments for insufficient documentation of medical necessity were just as high a source of denial for MPN providers as for others. There are also adjustments for medical necessity, prior authorization, and a general "not covered" reason that may also reflect documentation problems. For those line items that were paid, the fee schedule reductions almost completely accounted for any bill adjustments. A small amount of bill denials were attributable to going out of network.

Ms. Wynn stated that there are ways to close the gap between the promise and reality of MPNs. There are potential changes to MPN policies that could be considered. The MPN approval process could be revised, the rules that affect provider selection both by a payor and a worker could be modified, and a new independent medical review process for medical necessity disputes could be established. Ms. Wynn stated that she believes that the best way to unclog the Qualified Medical Evaluator (QME) system is to move out medical only disputes and then create incentives for delivering high-quality care.

Ms. Wynn stated that under the current policy, only the insurer or self-insured employer can apply for the MPN, and there is no separate approval process required unless there is material modification or major change in policy in the size of the network. A significant number of MPNs are operating under the emergency rules that were first approved and never have had to come in under current policies. Ms. Wynn stated that the Division of Workers' Compensation (DWC) has

no look-behind authority and has to rely on a complaint resolution process to identify issues. DWC has inadequate information to assess access and quality issues. If DWC does find issues, it cannot impose an intermediate sanction such as closing the MPN to new employers. With multiple MPNs being submitted by an applicant, it is administratively inefficient and there are no clear lines of accountability for meeting MPN access standards and no real way of measuring performance. There is a bewildering set of arrangements that confounds attempts to evaluate performance.

Ms. Wynn stated that potential policy changes would include allowing the applicant to be the group of providers or entity that establishes the MPN, which would preclude an insurer or employer from leasing a MPN from being the applicant, but would also allow HCOs to be certified on their own. This would greatly streamline the approval process, clarify accountability for meeting MPN standards, particularly of leased networks, and would facilitate evaluating MPN performance and effectiveness. The revised policy could require a re-certification process every two to three years, which could be a streamlined process where one would only report the policy changes. In addition, information is lacking on which employers are using the MPNs and what their geographic service area is. A number of states have separate reporting on an annual basis to know what is going on within the MPNs. The states also require MPNs to annually delineate their service areas and provide an updated listing of the provider membership. DWC could then assess the adequacy of the network coverage and the physician overlap; currently, DWC does not have a method for this assessment or for imposing an intermediate sanction for not following the MPN process.

Ms. Wynn stated that in terms of modifying the rules for provider panels, under the Labor Code, the insurer has the exclusive right to select MPN providers but not explicitly relieve payors of "due process" requirements. Participating physicians are only required to agree to the Medical Treatment Utilization Schedule (MTUS). The payor has to meet access standards, but there are no requirements for credentialing or quality assurance processes. Workers have to pre-designate a personal physician prior to injury; otherwise, the MPN is in control of the care throughout the life of the claim. One implication of the current policy is that most networks are broad-based with emphasis on fee discounting rather than quality and efficiency of care. There are many exceptions in terms of employers or payors who selected a network of high-performing providers, but currently, that is the exception rather than the rule. Most of them are leased network providers, and the providers within the networks may not be aware of their responsibilities. Workers are optimists and are unlikely to expect an on-the-job injury or illness, so they are unlikely to use the pre-designation process. Data on pre-designation are not readily available; data are usually in the worker's personnel file because there is not a systematic collection of information. Therefore, RAND has not been able to determine how many workers have used pre-designation.

Ms. Wynn stated that there is potential for modifying rules for provider panels. One requirement would be that MPNs that do not have HCOs would have credentialing qualities and assurance process to report annually on related activities such as prior sanctions, grievances and complaints, as well as provider educational opportunities. Since 50% of providers that are in the networks are inexperienced with workers' compensation, they do not understand all the rules. Another potential change would be to require some patient access and satisfaction measures that

include waiting times for appointments. Another potential requirement would be to strengthen the Labor Code provision that allows the applicant to selectively contact the providers. For instance, the Texas code specifies that the provider exclusive contracting is not a restraint of trade violation, and there are additional protections to leave out low-performing physicians and other providers. Requiring a written agreement between applicant and MPN specifying payor provider obligations would be appropriate, and the agreement could also specify that the physicians would treat workers' compensation patients, abide by the treatment guidelines and the referral rules to MPNs services, and detail fee schedule amounts. The rules could allow the injured worker to designate a personal physician as his or her primary treating physician after an injury. A "just in time" designation would be more meaningful that predesignation. Workers would have to document that they received the care from that physician prior to the injury, and the designated physicians would need abide by the MPN rules and refer only to MPN physicians. This "just in time" designation is a provision in the Texas MPN rules.

Ms. Wynn stated that the third refinement would be to establish a new Independent Medical Review (IMR) process for medical necessity disputes to replace the Qualified Medical Evaluator/Agreed Medical Evaluator (QME/AME) process. The current appeals process is time-consuming, and a high number of requests and expedited hearings occur. Current rulings on medical necessity issues are not decided by medical experts. Ms. Wynn stated that she believes that the current independent medical review (IMR) process as it is currently being utilized is dysfunctional because there is no need to utilize it; injured workers can shop around until they get the response they need. The IMR process using an external organization is used in group health, Medicare, and Texas workers' compensation. It increases the timeliness and appropriateness of decisions. The other change that may accompany the IMR process is to limit the number of times a worker may change providers within the same specialty without MPN permission. One may have the ability to change providers, but several states allow a maximum two changes from the initial provider before requiring permission, and this will reduce the "shopping around" and inherent inefficiencies in the system; every time the worker changes physicians, there will be some duplicate services provided. It is not efficient when one increases the reliance on the dispute resolution process to solve medical necessity issues.

Ms. Wynn stated that finally, changes would create incentives for delivering high-quality care efficiently. The incentives do not currently exist. From the providers' perspective, one has fee-for-service reimbursement, and from the MPN perspective, there is an inability to monitor performance. There are problems in selectively contracting with high-performing physicians. The implication is that there is an incentive for payors on fee discounting, and for providers, the incentives encourage excessive services and gaming the system rather than encouraging high-quality care.

Ms. Wynn stated that other potential policy changes are from earlier recommendations that would facilitate performance monitoring at provider and MPN level. Monitoring will help to create an efficient system. Public reporting currently is precluded in MPN performance. Allowing public reporting of MPN performance, like in Ohio, would create incentives for providing quality care. The new physician fee schedule certainly provides opportunity to create incentives for quality and efficiency for providers. Feedback to providers can also be extremely helpful improving performance, and it can be done by giving them the data.

Ms. Wynn stated that closing the gap between promise and reality of MPNs requires "win-win" policies for all parties. The policies should focus on policies and tools needed to create incentives for high-performing MPNs without unduly burdening "good performers." Ms. Wynn also stated that the policy recommendations discussed should reduce the administrative burden and complexity and should reduce the amount of contention and waste with respect to the appeals process, as well as should increase the confidence that care is appropriate and efficiently delivered.

Public Comments and Questions

Commissioner McNally stated that this discussion was insightful. Chair Wei stated that the MPN presentation captures many if not most MPN issues that had been flagged when MPNs were being started, and most the concerns have been brought to bear through Ms. Wynn's findings. Ms Wynn responded that she believes that MPNs have tremendous potential.

Public Comments and Questions

Dr. John Thrasher stated that he has been working in immuno-toxicology for many years. He stated that in one of Ms. Wynn's slides, she had discussed physical injuries that are seen. Dr. Thrasher asked about what is being done about unseen injuries such as chronic illness of the immune system. He stated that he is seeing an increase of the chronic immune response syndrome, and when that increases, diseases such as Parkinson's, multiple sclerosis and other neurological diseases are seen, and the reason for that is that the corporal brain system becomes chronically inflamed. Dr. Thrasher stated that he believes that nothing is being done to avert this situation. Ms. Wynn responded that Dr. Thrasher is correct, that they are not looking at preventive services but only services that are being provided. This is an ongoing study and it might look at preventive care. Dr. Thrasher further stated that Ms. Wynn stated that she had completed a scan of the literature, and he understands that it depends on how the programming the computer is done. He said it is critical to ask who is doing the programming and what type of information is being requested.

Jo Cinq-Mars, Orthopedic Medical Group of Santa Ana, stated that she wanted to comment about doctor shopping by the patient. Doctors get very frustrated with the system even though there are MPNs allowed, and they tell patients that if they have a problem with the doctor, they can always go to the licensing board. However, there are injured workers who have a doctor and the doctor, who is being pressured by the claims administrator or the insurance company, writes a Permanent and Stationery (P&S), yet that injured worker still needs care, and the injured worker has to go back into the system to pick another doctor. They are not necessarily doctor shopping; they are trying to get medical care.

Steve Zeltzer, California Coalition of Workers' Memorial Day, stated that this is an illuminating report because it states that they have to unclog the QME system. Ms. Wynn responded that the waiting times on QMEs getting the examinations; this could be improved if the cases where there is medical necessity are moved out of the process and an external review process is established. Mr. Zeltzer stated that it sounds from the report that the QME system is bankrupt and the system is not working to help injured workers, and what that means is that the patients who need surgery

and who cannot get care are being tortured. Mr. Zeltzer noted that in the survey in this study about seriously injured people, the most important question is how the seriously injured people feel about their injuries; those are the ones who have real problems that are not being addressed. Putting another bureaucracy in place is not going to solve the problems. One has to eliminate the insurance industry instead of adding another bureaucracy. He stated that Ms. Wynn suggests improving the system, but the reduction and waste by the insurance industry profits are not addressed. Ms. Wynn responded that this is not part of the scope of the study. Mr. Zeltzer then asked why profits should go to the insurance industry when instead, they should go to the health care provider; this issue does not seem to be part of the study. This also leads to further questions about why the profits should go to the insurance industry instead of workers who are injured on the job, and why the insurance industry should be in charge of care. Instead, profits should go to the health care for injured workers and to workers' compensation.

Mr. Zeltzer stated that he is unhappy with the comments of the Chair that the solution is to have more QMEs. Having more QMEs will lead to more doctors and additional bureaucracy. He stated that he does not want more QMEs, and injured workers do not want more QMEs; they want their injuries to be taken care of. The injured workers do not want the system to be "gamed" by the insurance industry so they end up being part of Social Security Insurance (SSI) and having the public be in charge of their health conditions. Mr. Zeltzer stated that there is massive cost-shifting going on in California and the rest of the country where injured workers are being treated for by the public for their injuries that happened on the job. There is a cost-shifting scam that has to be addressed by the public.

Linda Atcherley, California Applicants' Attorneys Association, stated that profiling of the doctors is a concern. As a practitioner who represents injured workers, she stated that doctors disappear from the MPNs; one day they are on the MPNs and the next day they are not, because these doctors recommend certain treatments. Ms. Atcherley believes that we cannot have that with IMR and uncertain treatment guidelines that have not been formally implemented by DWC and make it very difficult to move to an IMR system. Ms. Atcherley stated that when one talks about limiting change of physicians, one of the problems with the two-year TD cap, which does not take into consideration people who have multiple injuries. For a person who has a back injury and needs spinal surgery and who also has a hand injury and a psychiatric condition, the transition of care is through the different specialties and for the rest of the claim for the rest of his life. These cases are why one has to be very careful about further limitation of care.

Ms. Atcherley stated that she has been in this business for 23 years, and she acknowledges that there are problem areas, including gaming the system; most of the time, when people have one problem and they use one physician. When people have multiple problems, they use multiple providers, and as a result, there will be people who will "game the system." Ms. Atcherley stated that there are insurance companies that throw out perfectly good doctors because they do economic profiling, but that does not mean that there are good employers and insurance companies that will not do that. Ms. Atcherley stated that when one examines the care provided getting people back to work, we need doctors and QMEs who spend more than two and a half minutes with patients and produce reports that have careless mistakes such as describing a male patient as a female. She stated that it is critical to look at the care issues rather than just address simple fixes that do not add to the flexibility of the system.

Ms. Cinq-Mars stated that she would like the Commission to discuss review of the standards pertaining to MPN lists; doctors are added to the MPNs and then are removed from MPNs without notification. On any given day, AME doctors and other doctors do not know whether they are on or whether they are off the MPN list. Ms. Mars stated that when she calls for authorization, she finds out that the physicians are off the list, and her group is not give any reason why the doctors are removed from or added to the MPN list. She would like to see standards set up. Ms. Mars stated that in another instance, one MPN removed her group of physicians because discounts were being given on AME evaluations and that that was reason enough to be removed from the list of MPNs. Ms. Mar was only notified of being taken off the list of a particular MPN when she called for authorization.

Chair Wei stated that she would like clarification that Ms. Mar represents physicians who are being taken on and off MPN lists without notification. Ms. Mars responded that that was correct, that there was no indication and no notice. Chair Wei again asked whether there was no notice or indication when the physicians are removed from the list. Ms. Mar responded that patients are notified when physicians are removed from the list, but the physicians are not notified. According to Ms. Mar, being on and off the list is at the whim of the MPN or the adjuster. Ms. Mar would like standards to be set in regard to being on an MPN list.

Steve Cattolica, California Society for Industrial Medicine and Surgery and the California Society for Physical Medicine and Rehabilitation, stated that the recommendations provided by Ms. Wynn are wonderful. A bill was trying to make its way through the Legislature this year which has the same recommendations for MPN certification; those points were unsuccessful, but nonetheless, they will continue to move in the right direction. Mr. Cattolica stated that he wanted to assess the MPN penetration statistics. The University of Washington study noted the penetration and that 80 to 85 percent of MPNs were part of the MPN. Mr. Cattolica stated that he had created two of the MPNs that Ms. Wynn cited. They were created because of penetration, but originally they were created as an HCO. However, HCOs are not profitable except for PPO discounts. Mr. Cattolica stated that he had calculated that the "hit" rate for PPOs was roughly 47%. HCOs were allowing an increase of 90 percent or more. The PPOs that created the HCOs doubled their income. For MPNs, the penetration rate is significantly higher than the statistics Ms. Wynn showed. In the University of Washington study, in its identification of issues, 80% of the care was being provided by the MPNs, but presumably 80% of the problems that were also being identified were in the MPNs; they identified that $325 million in the first year after injury are being wasted. Mr. Cattolica stated that the waste should be addressed and that that would lead to better care.

Chair Wei stated that there is no action on this item at this time**.**

Break

A 10-minute break followed.

Preliminary Work on Prevention Research
John Mendeloff, RAND

John Mendeloff gave an overview of the status of four different studies on injury prevention that are in process, noting that there are not a lot of preliminary findings at this time. In 2009, CHSWC funded RAND to carry out several studies looking at the workers' compensation system and looking at different approaches to preventing injuries and illness. Most of the studies require obtaining injury rate information from different data sources, including the Workers' Compensation Insurance Rating Bureau (WCIRB), Workers' Compensation Information System (WCIS), Federal OSHA, and Employment Development Department (EDD). Data only became available in 2010, some as recently as May of this year. The study topics included:

- Would changes in California's experience rating in workers' compensation improve the prevention incentives provided to employers?
- How well has California's Injury and Illness Prevention Program (IIPP) prevented injuries, and what lessons could be learned from this experience?
- Is being new a risk factor for firms? What is the trajectory of injury rates as firm's age? What is the importance of interventions with firms as they age?
- Are there unusually effective Cal/OSHA inspectors? What could be learned from them about improving enforcement?
- Do apprenticeship programs in construction improve workplace safety?

Mr. Mendeloff stated that he would discuss each of the topics, except for the last.

Experience Rating as a Safety Incentive

Mr. Mendeloff stated that the motivation for this study is that California statute requires the Workers' Compensation Insurance Rating Bureau (WCIRB) to maintain a system of experience rating for employers for two purposes: to promote safe workplaces for California's workers; and to price premium appropriately based on employers' past performance. This issue came up in controversies at WCIRB. There is a threshold in terms of premium, about $13,000 over a period of three years, which a firm has to reach before it can be experience-rated. If the threshold were dropped, more small firms would be experience-rated. This might be a positive change if experience rating improved safety; if there is not much effect on safety, then a lot of firms, as well as WCIRB, would not have to deal with a number of issues. At this time, only 20% of firms are currently experience-rated.

Mr. Mendeloff stated that the study is looking at firms when they are first identified by WCIRB as being in existence and following of them over the next several years. Mr. Mendeloff stated that the methodology includes two measures: frequency of injury; and incurred costs as a percentage of premium. One of the preliminary findings was that in the first year that firms are in existence, they have very low reported injury rates, mostly because they are either not aware of reporting requirements or not aware how to report accurately. Analysis was limited to firms that had reported their data in the first year, and then these firms would be followed over two to five years. The data from the years before they are experience-rated indicate there is a small decrease.

Mr. Mendeloff stated that very preliminary results indicate possible evidence for a small impact of experience rating on claims rates, with the pattern for losses being ambiguous. The question is whether this is a big enough safety improvement to warrant expanding experience rating for small firms. In addition, a survey of small employers is being conducted to examine employer understanding of experience rating and the impact of experience on premiums. Small employers not subject to experience rating often think that experience affects premium; as a result, some of the impact of experience rating may be masked. There may be some implications both about educating employers and whether the thresholds should be changed.

Public Comments and Questions

Steve Zeltzer, California Coalition for Workers' Memorial Day, asked why the study did not include analysis of the elimination of Cal/OSHA medical staff and the effect on health and safety. Mr. Mendeloff responded that that was not the focus of the study; the focus was the effect of experience rating. Mr. Zeltzer stated that medical staff is critical to questions about health and safety. Chair Wei stated that the question would be considered later in the discussion.

Marc Gerlach, California Applicants' Attorneys Association, stated that it was his understanding that in addition to the threshold, the impact of the experience rating calculation increases as the size of the firm increases; therefore, the small employer, even after crossing the threshold, would experience little impact. He asked whether this was taken into consideration. Mr. Mendeloff responded that as firms get bigger, the change in premium will reflect more closely what happens with losses; the other part of the study is looking at larger firms and asking whether the formula should be changed.

California's Injury and Illness Prevention Program

Mr. Mendeloff stated that the objectives of the study on California's Injury and Illness Prevention Program (IIPP) were to identify the effects and policy implications of the IIPP in California. This study could potentially inform the national IIPP standard. The study is examining whether workplaces cited for not having an IIPP have worse safety records than similar firms that are inspected but not cited, and whether workplaces cited show improvements after being cited. IIPP requires workplaces to: assign responsibility for IIPP management; communicate with employees about safety; conduct periodic surveys of hazards and abate those that are found; investigate accidents; and train employers.

Mr. Mendeloff stated that enforcement policy is a key to success. Employers have to document that they have done these activities (less documentation is required for those with less than 20 workers). Violations are found in 25% of inspections, and this is the most frequently violated standard. He stated that 90% of violations are cited as general, rather than serious; and citations are about four times more frequent in small workplaces with first-time inspections. Firms need to provide documentation about meeting IIPP requirements. Mr. Mendeloff stated that the results in construction show that the percentage of inspections that cites IIPP violation is highest in accident investigations and referrals, but they are lower in complaint investigations and IIPP. In addition, they are lower in SIC 16, which is heavy construction, than SIC 15, which is residential construction, as heavy construction firms tend to be larger and more knowledgeable about

requirements. Mr. Mendeloff stated that the study looks at the early period in the 1990s and uses several data sources. More results are expected for this study, as well as the other studies, in the next few months.

Questions from Commissioners

Chair Wei asked about the data on residential construction. Mr. Mendeloff stated that there were violations in 28% of the inspections for this type of construction. Chair Wei asked if there is more double counting or whether there is just one violation, the IIPP, and Mr. Mendeloff responded that occasionally there is more than one, but not very often. Chair Wei asked for an explanation of the difference between complaint and referral. Mr. Mendeloff responded that complaint is from an employee or other legitimate party, and referral is usually from one inspector to another or from one agency to another. Chair Wei stated that it would be helpful to indicate number of incidents per each situation, and Mr. Mendeloff agreed.

Study on How Accident Risk Varies by Firm Age

Mr. Mendeloff stated that based on a number of studies, more experienced workers have less injuries than new workers. This would be also true for new firms, as they tend to have new and inexperienced workers and managers are often new. If there are much higher injury rates, then ways to intervene early should be considered, perhaps when they are getting a business license. It may also be important to make new firms aware of safety information early on. This has not been looked at before. California employment data are still coming in, so a preliminary study that looked at Pennsylvania data was done, and the methods from that study will apply to the California study with California data. The preliminary findings of the study with Pennsylvania data suggest that newness is a concern as a risk factor and that underreporting is a problem with new firms and needs to be addressed.

Study on Effective Inspectors

Mr. Mendeloff stated that there is evidence that OSHA inspections which carry penalties do reduce injuries at workplaces with less than 250 employees. If there is an inspection with a penalty, injury rates tend to go down 10 to 20% in manufacturing firms with less than 250 employees over the next couple of years following the inspection. One question that arises is whether some inspectors are better than others at doing things that reduce injuries, either because of personality or practices used in an inspection. The study talked with people in Cal/OSHA and federal OSHA. Findings indicate that more experienced inspectors are able to get more injury rate decreases than less experienced inspectors, and there is a slight indication that health inspectors are more effective than safety inspectors.

Mr. Mendeloff stated that another question is what percentage of an inspector's inspections did the inspector cite zero violations. The bottom 10% of inspectors cited zero violations in only 7% of inspections, and another 10% cited zero violations in 71% of inspections. Another question was in what percent of inspections of firms with unions with violations cited does an employee accompany the inspector. It was found that when an employee accompanies the inspector, more violations are identified.

Chair Wei asked if the data were California-specific or national, and Mr. Mendeloff responded that the data were California-specific. Chair Wei asked if there was a time frame for the data, and Mr. Mendeloff stated that he thought it was 1999 through 2006, and he would double-check the dates. He stated that the database will be expanded.

Mr. Mendeloff stated that this study is not being done to monitor individual inspectors but to identify the characteristics that are associated with better outcomes. The information may be of value to Cal/OSHA when considering the training it offers. Mr. Mendeloff stated that for 50% of inspectors, five standards cited the most account for 48% of all standards cited. Mr. Mendeloff stated that the data would be clarified, but at this stage, the data may indicate that some types of inspectors are more diligent than others. Mr. Mendeloff stated that the study will eventually look at a larger number of compliance officers and see whether there are lower injury rates following certain types of inspections.

Questions from Commissioners

Chair Wei stated that over the past few years, there appears to be a disconnect between Cal/OSHA and the Cal/OSHA Appeals Board, which has led to the Board throwing out violations for both technicalities and, even more disturbingly in her opinion, questions about the competency of the inspectors. There is legislation that suggests that consensus could be reached on what constitutes serious violations. There is a paucity of serious violations in California as compared to other states, and federal OSHA is emphasizing this issues. In the bill, language has had to be included that if inspectors have been certified by Cal/OSHA, the Appeals Board has to give them standing on the violation. Some Cal/OSHA inspectors have stated that they have lost the motivation to write citations because they feel the citations will be thrown out by the Appeals Board. This has created a drag effect on citations. Chair Wei suggested that the study should control for that issue to see if there is a pattern for some inspectors of citations being thrown out. Mr. Mendeloff responded that the study will look at that, and he will work with Cal/OSHA to identify the pattern of citations that are being thrown out by the Appeals Board.

Commissioner Aguilar stated that if officers do not want to write citations, there are loopholes in the system. Chair Wei stated that District Attorneys have to make priority decisions based on budget issues. Commissioner McNally stated that in his experience, different operations are run in agricultural areas and they appeal every citation. Nothing has been sustained as it was written at the Appeals Board level. Inspectors are inadequately trained, and they have a lot of pressure on them to write serious violations. They often write the violations without really understanding the codes, so in the appellate system, the violations can be rejected by the Board. There may be more pressure at some level to write more citations, but the people at the field level do not write citations that uphold scrutiny.

Chair Wei stated that there are a number of other issues involved. The Appeals Board often has scheduling issues and inspectors have to balance the Appeals Board schedule against the field schedule. She stated that she recognizes why a firm would attempt to appeal every citation, but it has become a pattern for most employers and that that has led to workers being exposed to dangerous conditions. Commissioner McNally stated that there is a serious credibility problem with the citations and appeals are one way of responding to that. Chair Wei stated that that is

something that she can agree on.

Public Comments and Questions

Mr. Zeltzer stated that there is no discussion of the reduction in the number of Cal/OSHA inspectors and the impact of that on health and safety. Mr. Mendeloff responded that they are looking at the effect of inspections, and if that is influenced by a reduction in the number of inspectors, that will be reflected in the study findings. Mr. Zeltzer stated that inspectors are not capable of doing an effective investigation in new industries such as biotechnology; medical doctors/inspectors are needed, but Cal/OSHA has no medical inspectors on staff. Mr. Zeltzer also stated that Cal/OSHA inspectors have been threatened by the Director of Cal/OSHA about where Cal/OSHA staff members are in their free time. He stated that there also needs to be a separation of self-insured and insured employers in the study. He then stated that if there is inaction on citations or protests about citations not being upheld, then unions should take actions to make the public aware of this situation through such means as press conferences, even strikes. Direct action should be taken to make the public aware of the problem. He stated that workers are often afraid to complain for fear of retaliation and firing. This has been the case for Massey and employers in the Gulf of Mexico. He stated that if one worker is intimidated, this will have an effect on other workers to not talk about health and safety. The study should look at this practice.

Alan Trichner, assistant to the Chief of Cal/OSHA, stated that they have met with Mr. Mendeloff to discuss data on training and how effective Cal/OSHA inspectors are. Cal/OSHA has tracked data on effectiveness of inspectors. They have found that if inspectors go to training, there is an increase in citations for the type of violations covered in the training. He stated that Cal/OSHA tries to establish consistency across inspectors so that employers are treated consistently. He stated that Cal/OSHA is very interested in the study data and findings and in making the program more effective. He stated that Cal/OSHA was also very interested in the findings of the IIPP study and is committed to improving this area. Chair Wei stated that that was good to hear.

Executive Officer Report
Christine Baker, CHSWC

Ms. Baker stated that staff has been working on the Commission annual report and other studies. The Request for Proposal (RFP) for an evaluation for continued return to work evaluation, permanent disability (PD) evaluation, and medical evaluation has been completed. RAND was the only contractor that applied, and their documentation and proposal were excellent. With the budget not yet signed, all contracts are on hold. She stated that she would keep the Commissioners posted as Commission staff moves forward with that contract.

Ms. Baker stated that at the last meeting, she spoke to the Commissioners about reviewing self insurance groups (SIGs). Commission staff has a small proposal to review SIGs again based on recent events in New York with significant solvency issues in this sector. The proposal would be under $5,000 and would be on hold until the budget is signed.

Worker Occupational Safety and Health Training and Education Program
Ms. Baker stated that she would like to advise the Commissioners that the Worker Occupational Safety and Health Training and Education Program (WOSHTEP) program has experienced budget reductions. The program collections and funding are tied to indemnity payments, and since the indemnity payments have gone down, the program has been reduced. Contracts have been cut by 35 percent this year. As a result, UCLA had to lay off one of their team members, and the Commission is cutting the contract provisions as well to reduce the contract.

Ms. Baker stated that Laurie Kominski, one of the casualties of the budget cuts, served as the Associate Director of Program Administration for the UCLA Labor Occupational Safety and Health Program (UCLA-LOSH). She was responsible for overseeing the implementation of WOSHTEP in Southern California and had a particularly significant role in the expansion of the Small Business Training and the Young Worker Leadership Academy (YWLA). The Commission is grateful for her dedication to promoting healthier and safer workplaces for all. Her contribution will be missed.

Ms. Baker stated that Robin Baker, who has served as Director of the Labor Occupational Health Program (LOHP) at UC Berkeley for nearly 30 years, will be taking a new position at the University this fall as Coordinator of "Research to Practice" for the Center for Occupational and Environmental Health. Her primary focus will be collaboration with the National Center for Construction Research and Training (CPWR). Robin was involved from the inception of WOSHTEP, helping to design and implement the over-all program, as well as programs in California and throughout the nation. Robin Baker will continue to work with the Commission on related projects.

International Forum on Disability Management (IDFM) 2010: Collaborating for Success
Ms. Baker stated that Commission staff has been busy being a partner and organizer for the International Forum on Disability Management (IFDM) 2010: *Collaborating for Success* that will take place September 20th, 21st and 22nd in Los Angeles. Over 30 countries are involved, and over 300 people are registered so far. Several Commissioners and former Commissioner Tom Rankin are participating in the event.

Proposal on Implementation of Benefit Notices Recommendations
Ms. Baker stated that two new proposals are presented for consideration. At the last Commission meeting, Commissioners approved a benefit notice study. Commission staff would like to take the next steps to develop the guidebook and key information and take the necessary steps to draft notices that would be streamlined in plain language. This would involve work with a team of technical advisors. There would be no additional costs, as technical support has already been included in this project.

CHSWC Vote
Commissioner Culbreath moved that the Commission revise the 2006 Guidebook for injured workers and develop recommended plain language for benefit notices, and Commissioner McNally seconded. The motion passed unanimously.

Class Action Suits in Workers' Compensation
Ms. Baker stated that the other project proposed today would be to examine the issue of class action suits in workers' compensation. Judge Lachlan Taylor stated that recently there was a class action in which applicants' attorneys were seeking to recover interest on awards for attorneys' fees. This case raises the question of why a class action on workers' compensation should be brought in civil courts. The Workers' Compensation Appeals Board (WCAB) does not have a procedure to handle those types of cases that have a class action procedure. Commission staff would like to examine the pros and cons of a class action suit process for those cases that need class action.

Commissioner McNally asked why those cases would not be covered under the exclusive remedy in workers' compensation. Judge Taylor stated that the argument was that the interest was part of the Appeals Board award; however, if you see this as a matter of interpreting the Appeals Board award, then it should be handled by the Appeals Board. The action went to a civil court in part perhaps because there was no adequate vehicle to bring that action where it belongs.

Chair Wei stated that class actions are not heard at the Appeals Board, and Judge Taylor stated that this is correct. Chair Wei asked if this was about the bottom line attorneys' fees or interest on those fees. Judge Taylor responded that it was about the interest. Commissioner Aguilar asked if the case went to the civil courts because it was not being addressed by the Appeals Board. Judge Taylor responded that the amount of money in interest involved was too small for the Appeals Board. This is the reason why class actions exist. Chair Wei asked how much interest was involved, and Judge Taylor stated that he did not know that specifically. Chair Wei asked if the Appeals Board deals with the interest in some instances but not in all, and Judge Taylor responded that that was correct. Commissioner Culbreath asked what this inconsistency was based on, and Judge Taylor stated that the issue was how to deal with small claims. Chair Wei asked why these cases were not being dealt with under existing law, and Judge Taylor responded that it may not be considered to be worth the trouble.

CHSWC Vote
Commissioner McNally moved to have the Commission develop an issue paper and analysis of alternatives for class action suits in workers' compensation, and Commissioner Aguilar seconded. The motion passed unanimously.

Public Comments and Questions

Mr. Zeltzer said that the issue is why there is one rule for one group and another rule for another group. Mr. Zeltzer stated that he would like to see the Commission undertake a study on WCAB judges. Mr. Zeltzer stated that there is conflict of interest on the part of workers' compensation judges, including who they are and where there are vested interests, if any, especially among employers and insurance companies. He stated that he would argue against an exemption the law that prevents going to civil cases.

Commission Staff Update
Ms. Baker stated that Commission staff continues to work very hard. The staff is dedicated and loves its work. Commission staff will be down another person for a while, as Denise will be on

maternity leave through February. Budgets are being cut, and staff has been on again, off again, and on again as of yesterday, with furloughs. This has caused some disruption to the work flow. This affects production of the annual report because many of the divisions within the agency are having the same problems of staffing and there are some delays in getting information.

Partnering on Forum Regarding Medicare Secondary Payor
RAND has suggested that the Commission partner on a forum regarding Medicare secondary payor. This would be no cost to the Commission. Commission staff would explore this and keep Commissioners informed.

Proposal on Educating Americans about Social Security Benefits
Ms. Baker stated that the National Academy of Social Insurance (NASI) has issued a Call for Proposals for projects to educate Americans about social security benefits and engage them in the policy process. Currently, Juliann Sum from UC Berkeley has done some work on preparing factsheets in this area for another organization on the interplay between workers' compensation and social security disability benefits and other public benefits. Commission staff would like to explore with UC Berkeley and other partners developing a proposal to submit to NASI to design information factsheets and distribution avenues, as well as evaluating the effectiveness of the engaging people in the policy process by increasing their understanding the gaps and redundancies between the different systems of benefits and helping them identify possible policy strategies to clarify and streamline the process for workers, injured workers, and others. The proposal is due September 15th, and approved projects will begin in October 2010 and continue through December 2011. This would be exploratory only at this time, and Commissioners would be informed of progress.

CHSWC Vote
Commissioner Aguilar moved that the Commission explore both the partnership with RAND on Medicare Secondary Payor Forum and the proposal to NASI for a grant on educating Americans about social security benefits, and Commissioner Culbreath seconded. The motion passed unanimously.

Ms. Baker thanked the Commissioners for their patience and support through some of the difficult times with budgets, staffing and workload.

Chair Wei stated that she speaks for all the Commissioners in expressing appreciation for the work of Executive Officer Christine Baker and the highly competent Commission staff and their continued dedicated work during difficult times. Chair Wei then stated that the Commission will meet next in December.

Request for an Annual Report Card for the System
Commissioner McNally asked whether it would be possible for Commission staff to put together a group of stakeholders to develop an annual report card for the system reporting on the insurance industry, self-insureds, private self-insureds, public entities, and non-litigated and litigated cases. This would facilitate determining how timely benefits are being paid, who is and is not performing well, and what the impact of delays in QME reports, underpayments, and

litigation is. This information could be looked at at least once, but perhaps annually, to determine which parts are and are not working efficiently.

Chair Wei asked what the scope of the report card would be regarding administering insurance claims, and Commissioner McNally stated that it would include claims but it would also include factors contributing to delays in payments and inaccurate payments. Commissioner Aguilar asked if the Audit Unit would look at these issues, and Ms. Baker responded that the Audit Unit only looks at issues on a selected basis; the first payment is not there. Ms. Baker stated that staff would look into whether the appropriate data could be collected and what such a study would involve. Commissioner Steinberg stated that this type of study is commendable and is within the Commission's mandate, and he expressed concern about Commission resources to undertake this project. Ms. Baker responded that staff could take the first steps of identifying what could be done and what types of resources would be needed. Chair Wei stated that Commissioners are asking staff to do that type of study and give Commissioners an update before the December meeting.

Public Comments and Questions

Mr. Zeltzer stated that he wanted to report that there have been a number of instances where workers have become sick from mold. One key case is in San Diego where the owner of the Poway Toyota dealership has refused to pay workers' compensation when workers have become sick. The District Attorney of San Diego, Cal/OSHA and federal OSHA have been advised. Mr. Zeltzer stated that federal OSHA is looking at this problem because Cal/OSHA is not doing its job. This is a serious problem for workers as well as the public at large. ACOEM is not addressing the problem of workers affected by mold.

Dr. Thrasher stated that his specialty is illness created by mold and other organisms. Many of these organisms are very dangerous and cause serious diseases. The American Thoracic Society did studies in 2007 that showed that the entire body could be involved in such diseases. The toxic particulates in the air expose everyone to illness. He cited his website and a published paper for more details on this subject.

Other Business

None.

Adjournment

The meeting was adjourned at 1:15 p.m.

Approved:

_____ _____

Angie Wei, Chair Date

Respectfully submitted:

_____ _____

Christine Baker, Executive Officer Date